Appendix B

Frequently Asked Questions

1. **What is data stewardship and why is it a major issue today?**
   Data stewardship is the management of health information by a health professional and includes collection, use, disclosure, management and security. Within each of these, there are medical-legal and ethical issues, as well as best practices that health providers should consider as stewards of health information in their trust. Physician stewardship of medical information is a well established trust in practice, and is legally enshrined in law.

   Data stewardship has become a major issue today because the Government of British Columbia has developed a long-term strategy for the electronic integration of information and communications among health care providers. The strategy is designed to improve access to and quality of health care for residents of the province.

   The major aspect for physicians is the voluntary transition from paper medical records to electronic medical records (EMRs). The responsibility for maintaining electronic medical records is the same as for paper medical records but the methods of collection, use, disclosure and management of information will change.

2. **What do I have to do regarding data stewardship?**
   During periods of major change, such as the transition to electronic medical records, physicians should:
   - Evaluate their practice’s processes for information management;
   - Develop/revise the practice’s data stewardship policies and guidelines;
   - Update the processes supporting and using the medical record;
   - Evaluate the availability and uses of external medical records.

3. **How does data stewardship help my patients and the public in general?**
   Physicians have a long-standing fiduciary duty as stewards of medical information on behalf of their patients. New information technology is significantly changing the structure and use of medical records, potentially affecting the privacy of patient information and the expectations of physician stewardship of that information. Above all else, the management of medical records, whether paper or electronic, must ensure the security and privacy of patients’ health information and the integrity of that information.

4. **How does the Personal Information Act (PIPA) apply to medical records in physicians’ group practice?**
   There are several aspects:
   - Unless otherwise specified, physicians in a group practice have joint ownership of the medical records of the group and are jointly responsible and accountable;
   - In a group practice, each medical record must indicate the physician who is most responsible;
   - If a physician enters a medical practice network, the details of the information-sharing protocols and the ownership of the medical records must be contained in a formal, written agreement;
   - Referrals and transfer of care must be documented even if in a group arrangement;
   - The use of an integrated record is acceptable, however each entry in the integrated record must be attributable and the unified record must not compromise the ability to provide patients access to their information;

5. **Who owns the medical record, what can I use the record for, and who can have access?**
   The person or practice that has the custody and control of the physical medical record is considered the owner of the record. The individual patient has the basic and controlling interest in the information contained within the physical record but the patient information is held in trust by the physician custodian of the record.

   Any information collected in a therapeutic context is considered health information and should be collected in the pursuit of diagnostic and treatment goals to benefit the patient. Access is limited to the physician who collected
the information, although it should be further limited to those with a need to know. Any access outside the practice or organization would be considered a disclosure.

6. What can I disclose? What do I have to disclose? What can I prevent from disclosure?
Physicians have a professional obligation to manage the confidentiality of the patient information in their care and also have specific duties and obligations to manage disclosures. The following needs to be considered regarding disclosures:

- Disclosures to third parties should be based on policy of explicit and informed consent unless otherwise authorized by law;
- Patients’ general right of access to their medical record is not absolute; if there is risk of a substantial adverse effect on their physical, emotional or mental health or harm to a third party, a physician may deny access to a record;
- Physicians are responsible for acting as custodians for individual or systematic disclosures from the medical record, including the actions of group practice partners, affiliates and information service providers;
- Physicians are not responsible for the actions of another organization’s use of information once it has been legitimately disclosed;
- Physicians should determine the purpose of disclosures (even with the existence of consent) to make the appropriate level and detail of disclosure to meet the defined purpose; disclosure should be limited to scope of work;
- Medical records should maintain a record/audit trail of such disclosures.

7. Can I engage an information service provider to handle my medical records? What if the information service provider is also a custodian, such as an RHA or another physician group?
Physicians may engage an outside or contract Information Provider Manager but there must be a legal contract that defines information uses and disclosure, and that specifies that physicians have full control of the information. An Information Provider Manager may be an organization or affiliate acting in an information service provider role.

8. What is the difference between an electronic medical record and an electronic health record?
An electronic medical record (EMR) is provider-centric in that it focuses on medical or physician specific information and is configured to reflect the needs of individual physicians or groups of physicians who are directly caring for a patient. Physicians must keep a medical record for each patient and are the custodians of the information in the record.

An electronic health record (EHR) is a patient-centric document that may contain information from a broad range of providers, e.g. physiotherapists, social workers, dietitians, etc. who have contributed to the care of the patient. It generally contains a subset of sharable information including cumulative patient profiles with details on current prescriptions, allergies and immunization history.

9. Accessing an EHR - do I have to look up data for every patient I see or can I be selective?
Physicians should use their judgment to determine whether to access information from an EHR. Criteria should include: patient condition and ability to provide information, risk to patient privacy, and the potential for improved quality of care.

Medical-legal reasons to access an EHR include:
- the review of previous care and treatment of a patient*;
- monitoring patient compliance with physician orders;
- monitoring the outcomes of treatments or referrals.

*It is valid to evaluate the previous care a patient has received. In some cases, failure to use available information has been deemed “a critical omission” in legal proceedings.

Situations where the use of an external medical record is ethically valid include:
- emergency care, especially if the patient is incapable of providing information;
- assuming the care of a patient when there is limited background information, the complexity of the patient is high or after major treatment by a facility or other physician;
- providing a second opinion to a patient.

11. What information in an EHR am I responsible for recording in my medical records?
Information accessed from an EHR remains the custody of the originating physician, health care provider or healthcare institution. The custodian of the external medical record, rather than the user of the information, has the responsibility to record the disclosure. Physicians should record information from an EHR if it materially alters the treatment or care of a patient, or if it is not collected as part of the receiving physician’s medical record.

Information transmitted from the external record to the physician record becomes part of the physician record and the receiving physician becomes a custodian of that collected information. Information collected in this manner should be limited to scope of care provided and should maintain the chain of trust from the original record, including masking capabilities.

12. I receive lab reports I didn’t order – do I have to follow-up on the report? What do I do with the report?
A duty exists to review order results, consultant notes or other information received in response to physician orders. This includes a review of treatment received and the follow-up recommendations for the patient. Physicians who receive information for current patients where they did not initiate the order, can:
  - discharge the duty by assigning follow-up responsibility action to another physician who accepts the responsibility;
  - accept responsibility for the follow-up;
  - note the receipt of the information but not acknowledge responsibility for follow-up.

Regardless, a physician should document the receipt of the information in the medical record as well as the action or inaction taken. This duty does not extend to information received where no physician-patient relationship has ever existed.

13. I receive reports from the lab and I see that they are all on the EHR. Do I have to continue to receive the reports or can I look them up when I need to?
Physicians may use the EHR as the mechanism for the delivery of test results and should confirm the receipt of the results as if the orders were delivered in document form. A formal agreement between a physician and the diagnostic facility is required to discontinue the normal distribution of diagnostic reports.

14. Our practice shares on-call rotation with another practice. Can we grant each access to our EMRs? Can we update their records?
In instances where multiple medical records exist, explicit policies must identify which records need updating and under which circumstances so that all components of the patient record are gathered into one location, and the transfer of care and follow-up of orders is clearly identified and managed.

15. I want to use my EMR data to perform my own quality assurance evaluation. Is this legal? How about a clinical trial of a new medication?
A valid purpose for use of health information is health services planning, maintenance or improvement, so internal quality assurance is valid. However a clinical trial would require consent and/or an Ethics Review Board approval prior to any disclosure. The evaluation by the physician of patient data to determine eligibility for participation in a clinical trial would be a valid use of the data, but this information could not be disclosed without patient consent.

16. Do I have to switch to an EMR from my paper records? What is involved in the transition?
There is no obligation to transfer from paper medical records to electronic medical records. EMRs are an acceptable format for storing health information and physicians who choose them must ensure during the transition phase that:
  - patient information is secure;
  - privacy of patient information is maintained;
  - the integrity of the medical record is maintained;
  - the integrity of the clinical workflow supported by the medical record is maintained;
  - continuity and quality of care is maintained through the transition period.

17. What is involved in putting information on an EHR? Am I responsible for how others use the information I post? Who can see, and use, my information?
Physicians have the legal authority to post patient encounter information to an EHR. They also have an obligation to know the rules of access and to provide the appropriate level of detail necessary for the clinical objectives of the disclosure.
Physicians retain custodial responsibilities for information disclosed to the EHR; however, they are not responsible for the subsequent uses and disclosures of that information. Disclosures should be limited to information collected or confirmed by the practice as part of the patient encounter while information provided by third parties may be omitted.

If information is to be posted where a physician is not the originating organization, it should be identified as such. Disclosures, consents, denials of consent, and limitations on disclosure should all be documented in the medical record.

18. What is masking?
Masking is the application of rules that restrict access to data in an electronic record unless additional action is taken to override the restriction. However, the existence of such information is acknowledged.

19. What is blocking?
Blocking is an application of access restriction where the existence of the data is not presented. A physician should consider the patient’s expressed wishes to prevent or limit disclosures to an EHR except where mandatory reporting is required.